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	175385	A. BUILDING _____ B. WING _____	C 05/23/2012

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F 000	INITIAL COMMENTS The following citation represents the findings of an Abbreviated Survey #IW4011 and Complaint Investigations #57002, #57190, and #56953.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility census totaled 98 residents. The facility reported 29 residents resided on the Sunflower neighborhood on May 6, 2012. Based on observation, interview and record review the facility failed to conduct a thorough investigation of an allegation of resident abuse, failed to ensure staff immediately notified the administrator or designee of an allegation of abuse and failed to protect the 29 residents residing on the Sunflower neighborhood. Findings included: - On May 7, 2012 the facility reported an allegation of an employee to resident abuse. The facility's self-investigation report dated 5/11/12 included 5 notarized witness statements from staff who worked the evening and night shifts on May 6, 2012. Review of the 5 witness statements revealed 4 additional staff were present during the incident. The report failed to include any witness statements from the 4 other staff who also worked the evening and/or night shifts on May 6, 2012. The allegation of employee to resident abuse was re-triaged for an onsite investigation. Review of resident #5's physician's order sheet dated 5/1/12 included the following diagnoses: chronic (of long duration) back pain, hypertension	F 225		

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(high blood pressure), dementia (a decline in mental ability severe enough to interfere with daily life) without behavior disturbances, depression (extreme sadness), anxiety (a feeling of worry, nervousness, or uneasiness) and agitation (excessive, purposeless restlessness usually associated with anxiety).

Review of the resident's significant change MDS dated 6/20/11 identified the resident with severe impairment of cognitive skills for daily decision making, experienced inattention and disorganized thinking and without behaviors during the assessment period. The resident required extensive assist of 2 persons for bed mobility and transfer.

Review of the resident's most recent quarterly MDS (minimum data set) dated 2/14/12 identified the resident with severe impairment of cognitive skills for daily decision making. The MDS revealed the resident experienced inattention and disorganized thinking. The MDS also identified the resident required extensive assist of 2 persons for bed mobility and transfer, and required the use of a mechanical lift.

The Cognitive Loss/Dementia CAA (care area assessment) dated 6/20/11 further identified the resident experienced both long and short term memory loss and needed staff assistance with daily decisions.

The ADL (activities of daily living) Function/Rehabilitation Potential CAA dated 6/20/11 revealed the resident required 2-3 staff to assist with all of his/her ADL's.

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The care plan last reviewed on 2/12/12 revealed the resident experienced severe impairment related to Alzheimer's Disease. It instructed staff to introduce themselves to the resident and approach in a calm manner, explain care prior to providing, and talking him/her through cares, introduce new materials in a gradual and non-threatening way and observe for frustration or irritability. It also instructed staff to, If possible, change the activity and gently attempt to redirect attention.

Review of nurses' notes dated 5/6/12 at 0510 (5:10 a.m.) revealed the resident "was anxious and up in the recliner." At 2:00 p.m. a nurse documented the resident "was very agitated and anxious all shift." PRN (as needed) ativan (a medication used to decrease anxiety) was given without being effective. The staff performed a urine dipstick which had negative results. Staff provided a whirlpool bath to promote relaxation. At 9:00 p.m. the nurse wrote that the resident continued with restless agitation and needed 1 on 1 attention much of the shift for the resident's safety. At 10:00 p.m. the nurse documented, "the resident closes eyes, twitchy and jerky then stated, 'have to get going,' nurse sat with the resident to calm."

Review of the Daily Staff Sheet dated 5/6/12 revealed staffing on the Sunflower neighborhood included on the evening shift 1 charge nurse and 4 aides. The night shift included 1 medication aide and 2 aides.

At 9:45 a.m. on 5/22/12 observation revealed resident #5 laid in bed resting quietly. The resident presented calm and received oxygen

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through a nasal canula (type of tubing). A mat laid on the floor in front of the resident's bed. The bed rested in low position with a quarter size rail on the outer side of the bed in the up position.

On 5/22/12 at 10:06 a.m. observation revealed direct care staff A and direct care staff B assisted the resident from the bed to the bathroom using a sit to stand lift. The resident cooperated, made grunting noises, and stated, "Oh, my," as direct care staff A and B assisted the resident to a standing position on the lift. Both direct care staff A and B explained to the resident what they planned to do and allowed time for the resident to respond.

On 5/22/12 at 2:20 p.m. observation revealed the resident sat in a recliner chair in the living room area in a reclining position. The resident laid in the recliner with eyes closed.

On 5/22/12 at 9:50 a.m. during an interview direct care staff A, he/she reported the resident required extensive assist of 2 persons with transfers. Staff A reported the resident required the use of a sit-to-stand lift for all transfers. Staff A identified the resident as very confused and could easily become anxious.

On 5/22/12 at 10:45 a.m. during a telephone interview, direct care staff C reported that direct care staff D arrived on the floor before he/she did for the night shift on May 6, 2012. Staff C reported that when he/she saw staff D, he/she was upset and asked why resident #5 remained up in the recliner chair. Staff C reported that he/she tried to tell staff D that it was ok that the resident remained up and that it was easier to

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watch him/her. Staff C reported that the evening shift staff told him/her that the resident had been restless and anxious most of the shift. Staff C stated that staff D tried to force the resident onto the lift by grabbing the resident's arm. Staff C reported that licensed nursing staff E stepped in and told Staff D to stop, but Staff D continued to argue and attempted to put the resident on the sit-to-stand lift. Staff C confirmed he/she had worked the rest of the night shift with Staff D. Staff C reported staff D was angry about the situation with resident #5 but he/she did not see any further rough or rude behavior towards any other residents the rest of the shift. Staff C reported he/she was not with Staff D all the time during the shift, especially when they assisted their assigned residents to get up in the morning.

On 5/22/12 at 11:00 a.m . direct care staff F, during a telephone interview, confirmed he/she had worked the 2-10 p.m. shift on the evening of 5/6/12. Staff F reported that direct care staff D acted rude to staff and in a loud demanding tone of voice asked why resident #5 was still up in the recliner chair. Staff F reported after the 2-10 shift staff explained to him/her that the resident acted restless and agitated most of the shift. Staff D became angry and agitated at licensed nursing staff E while he/she continued to put the resident on the sit-to-stand lift. Staff F reported he/she heard Staff E instruct Staff D that if the resident said no, he/she was to leave him/her up in the recliner chair. Direct care Staff F reported that he/she saw the resident striking at direct staff D as staff D continued to try to get the resident to hold onto the lift. Staff F reported that licensed nursing staff E intervened and insisted that staff D stop. Staff F stated, Staff D continued to try to

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pull the resident on to the lift by pushing the resident on his/her back. Staff F reported that again he/she heard licensed nursing staff E tell direct care staff D to stop. Staff F stated he/she then picked up the trash and left the building and went home.

On 5/22/12 at 3:15 p.m. during an interview with direct care staff G revealed he/she witnessed the incident that involved resident #5 on the night of 5/6/12. Staff G reported that direct care staff D grabbed the resident's arm and tried to get him/her up in the sit-to-stand lift. Staff G stated staff D acted rude to staff and was angrily insistent that the resident needed to go to bed and that he/she was tired of the residents always being up when he/she came on the shift. Staff G reported he/she had told staff D that this was the resident's home and he/she did not need to go to bed, but staff D would not listen. Staff G stated, "I went directly to my charge nurse and reported [staff D]."

On 5/22/12 at 4:35 p.m. during an interview with direct care staff H revealed Staff H did rounds with Staff D on the evening of 5/6/12. He/She reported that staff D was not focused on making rounds but was upset about resident #5 being up in the recliner. Staff H reported that he/she witnessed staff D arguing with licensed nursing staff E. Staff H stated he/she saw staff D grab the resident's arm above the elbow and forcefully pull the resident towards the lift. Staff H reported that he/she thought licensed nursing staff E did all he/she could to make staff D leave the resident in the chair. Staff H stated that when the arguing got loud, and staff E was handling it (the situation) and he/she knew he/she could not do

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F 225	Continued From page 7 anything more, so staff H left the building and clocked out. During a telephone interview on 5/22/12 at 12:00 p.m. licensed nursing staff E reported that staff D came off the elevator and saw residents sitting in the recliners in the living area and stated, "that just set [gender] off." Staff E reported that Staff D became upset and angry that the resident remained up and was not in bed. Staff D started to make rounds on the short hall and continued to "rave" about resident #5 being up in the recliner chair and needed to be put to bed. Staff E stated the evening aide (staff G) reported to him/her that [gender] could not continue rounds with Staff D because he/she was so angry. Licensed nursing staff E reported he/she then went and talked to staff D about the residents being up. Staff E reported he/she informed staff D that the resident was agitated most of the shift and required 1 on 1 observation for safety. Staff E stated that he/she told staff D that the resident had just settled down and needed to be left up in the recliner chair. Staff E described staff D's demeanor as "angry and would not let up." Staff E reported he/she observed staff D push the lift in front of the resident, grabbed the resident's wrist and pulled his/her arm towards the lift handles trying to get the resident to hold on, but the resident swung at Staff D and stated "no, no." Licensed nursing staff E reported, at that time he/she went over to staff D and insisted staff D leave the resident alone. By that time, licensed nursing staff E stated that the resident was already in a standing position on the lift. Staff E stated, "Finally, after numerous commands to staff D to put the resident down, staff D lowered the resident to the recliner and stormed to the elevator and went	F 225		

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down stairs. Staff E reported he/she did not see staff D after that until he/she was ready to go home and passed him/her downstairs as Staff D headed back upstairs. When asked if he/she felt staff D was rough with the resident staff E stated, yes, "Staff D jerked the blanket off the resident and grabbed the resident's arm." Staff E reported that he/she told licensed nursing staff J about the incident. Staff E stated that she reported the incident to administrative staff I the next morning. Staff E reported he/she did not know if he/she could send someone home, but did say that administrative nursing staff I could be called if he/she had any questions.

During a telephone interview with licensed nursing staff J on 5/22/12 at 4:45 p.m. Staff J reported that he/she rode up in the elevator with Staff D after the incident occurred. Staff J reported that Staff D told him/her that he/she got himself/herself in trouble. Staff J stated he/she did not ask staff D what had happened because he/she figured licensed nursing staff E would tell him/her when he/she gave report. Staff J stated that staff E reported to him/her that the resident had been restless and agitated most of the shift and the resident just had quieted down and was resting in the recliner chair when staff D came on the shift. Staff J stated that Staff E reported to him/her that staff D was very angry that the resident remained in the recliner chair. Staff J reported staff E informed him/her that staff D was insubordinate and kept insisting that the resident be put to bed and that staff D attempted to put the resident to bed when the resident kept saying no. Staff J stated, "I asked staff E if staff D stopped when told to and Staff E told him/her yes." Staff J reported he/she only thought it was an issue

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between the aide and the nurse.

On 5/22/12 at 11:45 a.m. during an interview, administrative nursing staff I stated, "staff know they can call me anytime with questions." Staff I confirmed both nurses failed to recognize this incident as an allegation of resident abuse. He/she also confirmed Staff D worked the entire night shift and neither licensed nursing staff E or J removed Staff D from the unit or immediately called him/her or the administrator about the incident. Administrative nursing staff I confirmed no one notified staff I of the incident until around noon on 5/7/12.

On 5/22/12 at 2:30 p.m. administrative nursing staff K reported staff should have notified administrative nursing staff I of the incident or any allegation of abuse. Staff K confirmed the staff failed to follow the facility's policy and protect the residents by removing the alleged perpetrator.

Review of the facility's Abuse Policy dated 2/10/12 instructed staff that "if any staff member suspected or had actual knowledge an elder was being neglected, exploited, or abused, they shall immediately report such suspicions to the Director of Clinical Operations, Director of Human Resources, Administrator, Green House Guide, Chief Executive Officer or next person in charge without delay. This is in all cases and regardless of the alleged perpetrator... This may be completed in writing or orally."

The policy also instructed staff in section V. a., "that upon being notified or becoming aware of allegations of neglect, exploitation, misappropriation of property, abuse, or injures of

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F 225	Continued From page 10 unknown origin, the person in charge will immediately call the abuse hotline (provided the number) and report the suspected neglect, exploitation or abuse and inform the hotline personnel that the situation is under investigation. Immediately after calling the abuse hotline, the person in charge will begin an internal investigation of the situation. The investigation will be conducted by or under the direction of the Director of Clinical Operations." Section V. c. 1) included that, "should actual involvement be confirmed or if there is reason to believe actual involvement is a fact, the alleged perpetrator will be suspended and not allowed in (facility name) unless specifically so instructed." The facility failed to conduct a thorough investigation of an allegation of resident abuse, failed to ensure staff notified the administrator or designee of an allegation of abuse and failed to protect the 29 residents residing on the Sunflower neighborhood.	F 225		